

# PHYSICIAN'S REPORT OF EMPLOYEE INJURY

To be sent with injured employee and given to physician

All referrals for testing or to another doctor require authorization. All bills for authorized medical treatment must have corresponding medical notes attached and should be directed to:

OccuSure Claims Services, P.O. Box 681923/ Franklin, TN 37068 877-622-7870/ FAX 877-622-7871

## TO BE COMPLETED BY EMPLOYER PRIOR TO TREATMENT BY PHYSICIAN:

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact: \_\_\_\_\_

Name of Injured Employee: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Description of Incident: \_\_\_\_\_

Body part(s) To Be Treated: \_\_\_\_\_

Authorized Employers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employees Signature (for treatment on the above injury): \_\_\_\_\_ Date: \_\_\_\_\_

## TO BE COMPLETED BY TREATING PHYSICIAN:

Date of First Treatment: \_\_\_\_\_

Initial Complaint: (\*NOTE TO TREATING PHYSICIAN: Employee is to be treated for the injury listed above. Any other treatment that is not related must obtain prior authorization.) \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Nature, extent, degree, body location of injury: \_\_\_\_\_

Treatment Prescribed and Prognosis: \_\_\_\_\_

Medications/Testing Prescribed: \_\_\_\_\_

X-Rays taken  Yes  No If yes, results:  Positive  Negative

Was there any evidence of a prior or pre-existing injury or illness \_\_\_yes \_\_\_no If yes, what condition and to what extent may it contribute to incapacity or recovery? \_\_\_\_\_

To help employees return to work more quickly, a temporary modified/light duty program is available, this employee:

May return to work today without restrictions  May return to work today with restrictions as indicated below for \_\_\_\_\_ days

May not return to work until \_\_\_\_\_ Reason \_\_\_\_\_

If restrictions are required, please indicate below

- |  |   |
|--|---|
| <input type="checkbox"/> No standing over _____ hrs.             | <input type="checkbox"/> No lifting over _____ lbs    |
| <input type="checkbox"/> No overhead reaching                    | <input type="checkbox"/> No stooping/bending/twisting |
| <input type="checkbox"/> No use using _____ hand/upper extremity | <input type="checkbox"/> No walking over _____ hours  |
| <input type="checkbox"/> No climbing                             | <input type="checkbox"/> No weight bearing _____ foot |
| <input type="checkbox"/> No pushing/pulling over _____ lbs.      | <input type="checkbox"/> No operation of machines     |
| <input type="checkbox"/> Keep wound clean, dry                   | <input type="checkbox"/> Other: _____                 |

**Drug/Alcohol Screen is Required for Initial Visit**  
Completed  
 Yes  No  
**Results should be sent to Employer**

Released to restricted duty on \_\_\_\_\_, 20\_\_\_\_ Released to regular duty on \_\_\_\_\_, 20\_\_\_\_

Will employee require further medical treatment? \_\_\_No \_\_\_ Yes, PRN \_\_\_ Yes If yes, date of next appt: \_\_\_\_\_

Expected date of MMI \_\_\_\_\_ Please explain \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Name & Address: \_\_\_\_\_